California State Innovation Model (CalSIM)
Accountable Care Communities (ACC) Work Group
February 26, 2014
Notes

Attendees: Jeremy Cantor, Prevention Institute; Ron Chapman, CDPH; George Flores, TCE; Liz Gibboney, Partnership Health Plan; Laura Jones, Santa Clara Health and Hospital System; Barbara Masters, CalSIM; Kelly Miller, IHA; Connie Mitchell, CDPH; Mary Pittman, Public Health Institute; Steve Shortell, UC Berkeley; Loel Solomon, Kaiser Permanente; Marion Standish, The California Endowment; Anne Sunderland, Public Health Institute; Jessica Tomlinson, Public Health Institute
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I. Background:

In June 2012, California put together the Let's Get Healthy California Task Force to identify what it would take for CA to be the healthiest state in the country by 2022. By December 2012, California produced a report which identified six priority areas in health and healthcare. California's LGHC effort dovetailed well with the Centers for Medicare and Medicaid Innovation's (CMMI) State Innovation Model (SIM) Grants. In March 2013, California formed six work groups around the six LGHC goals in anticipation of a SIM Design Grant to identify interventions that would help advance LGHC and reduce the overall cost of healthcare. CMMI's priorities included demonstrating costs savings, having a multipayer approach, and seeding innovations that would reach a large percentage of the population.

A work group formed around the LGHC priority area of Creating Healthy Communities. This work group developed the idea of the Accountable Care Community, which was included as an initiative in California's State Health Care Innovation Plan (Innovation Plan). The draft Innovation Plan, available on the CHHS website, will form the basis for forthcoming State Innovation Model testing grant. Testing grants are expected to be ~$60 million over a 3 year period; a funding opportunity announcement is expected to be released soon. The State will be putting together a grant application in the spring and, if accepted, the grant is anticipated to begin in the fall. The California foundations have offered interim funding from April through September so that California can conduct planning with regard to the initiatives and building blocks outlined in the Innovation Plan. Given CMMI's requirement to demonstrate an ROI in three years, this will advance California's chance at success. The ACC is one small component of California's Innovation Plan, with the emphasis of the plan being on health homes for complex patients.

The goal of the ACC work group is to design a model that brings together the health care system with social services and community resources. An ACC works to improve the health of the entire community – not individual members of a health plan or medical practice group. This work group will design a draft RFP for consideration by the state; it will be issued once California receives the CMMI Testing grant and will result in the selection of 2-3 pilot sites to develop an ACC.

It is critical that there be a three-year ROI to establish a proof of concept for this initiative. This work group will also identify key parameters of a wellness trust, which is an important financing and sustainability mechanism for the ACC. The Innovation Plan identified three target conditions that an ACC could focus on: asthma, diabetes, and cardiovascular disease. These were chosen for prevalence, existence of disparities, and the ability to generate an ROI. In previous meetings, work group members agreed that an ACC should be established in communities which have a high degree of readiness in order to guarantee success. The work group has drafted some criteria for possible pilot sites; these were sent out prior to the meeting.

Work group members had several questions:

- One member wondered if an ACC must be budget neutral in the way that Medicaid Waivers are? At this time, it is unclear if this is a requirement, but the ACC does need to demonstrate an ROI.
- Work group members also wondered what proportion of the grant dollars will be directed towards an ACC. Since the FOA has not yet been released, CalSIM has not developed an overall budget or budget allocation at this time.

II. ACC Program Design

Barbara Masters referred members to the agenda and meeting materials that were distributed before the meeting. The meeting materials contain a draft list of elements that an ACC should include:

1. Be a collaborative of the majority of public and private health care systems, providers, and health plans, along with public health and community and social services organizations serving a particular area.
2. Initially target a particular chronic condition and be able to reach 75 percent of individuals in the geographic area with that condition. *Discussion*: *This was included to ensure that the ACC reaches the whole population, not just those individuals in a certain health plan.*
3. Operate at the county level, or in the case of smaller counties, be a multi-county collaborative. *Discussion: This item is up for discussio--, an ACC may want to be based in a defined by other boundaries, such as service/catchment areas. The group believed that the applicant should define the community size for the ACC.*
4. Implement specific program interventions initially in areas that are "hot spots" for the condition and/or include high rates of disparities for that condition; also include contiguous areas so as to also serve the broader community. *Discussion:Perhaps the ACC could start in an area where a high level of the population has the target condition.*
5. Initially focus on secondary prevention interventions to demonstrate proof of concept and document health and cost outcomes. *Discussion: Ultimately, the ACC should move into primary prevention activities.*
6. Identify medium and long-term goals that will guide the ACC to expand its target population, condition, and geographic area, as well as to implement primary prevention strategies, such as policy and environmental changes. *Discussion: While the ACC needs to demonstrate a short-term ROI, this criterion will set a clear long-term goal.*
7. Identify the entity that will perform the backbone/integrator function. Key functions include:
    - Lead the development and prioritization of goals and strategies

- Facilitate the evaluation (with an outside facilitator). *Discussion: Clarify that the backbone does not conduct the evaluation*
- Facilitate the development of agreements among collaborative partners
- Facilitate the development of shared savings or other financing mechanisms
- Identify data needs and facilitate data sharing mechanisms (e.g. through HIE)
- Coordinate the implementation of intervention(s)
- *Discussion: Other backbone functions include: facilitate problem solving and conflict resolution; provide quality assurance across entities as a check for incentives for inappropriate cost-savings*

8. Identify the entity that will act as the Wellness Trust (may be the same or distinct from the backbone/integrator function) with an accountable governance structure
9. Potential examples of backbone and/or Wellness Trust hosts include:
    - Neutral and respected local non-profit, such as the United Way
    - Local or regional community foundation
    - Health District (e.g. Beach Cities Health District serves this type of role)
    - County health department
    - Entity from outside the county/region if no local host exists with the necessary capacities

The first six elements represent the operational components of an ACC, a key point of discussion will be how to generate an ROI in three years while laying the groundwork for upstream interventions; element #7 refers to the backbone/integrator function which work group members have previously suggested is an essential component of an ACC; and numbers 8-9 refer to the wellness trust concept which will be embedded into the ACC. The wellness trust idea is loosely based on the legislation that Massachusetts enacted last year. Massachusetts's trust leverages an assessment that was levied on hospitals and health plans. However, California is looking at other funding options that are locally determined -- such as a portion of hospital community benefits money, community reinvestment dollars, being a recipient of shared savings, etc. CMMI testing grant monies may seed the wellness trust. A wellness trust is currently being discussed in San Francisco as are social impact bonds in Fresno.

Work group members discussed the pros and cons of having two or three pilots. While three pilots may establish a better proof of concept, there may be more resources available for two pilots. Work group members briefly discussed an outreach campaign to promote a learning agenda in communities around the state to stimulate interest.

A. Operational Components for an ACC

Work group members discussed possible geographies for an ACC, questioning why the ACC should be formed along political boundaries. Work group members saw advantages and disadvantages of defining geography around county lines. The county health departments may have resources which would benefit an ACC; however, counties do not line up with health plan service areas. Community Health Needs Assessment (CHNA)boundaries or hospital service areas may be a more logical catchment area for an ACC. Some hospital service areas in Northern California are collaborative. However, it is important to note that hospitals often divide a service area around a low-income hotspot so that no one hospital is responsible for that area.

Work group members talked about giving examples of what an appropriate service area would be but not delineating prescriptive parameters. One work group member suggested that the work group define parameters around the size of the population, although this may exclude small, rural areas unless they band together. Another work group member noted that it will be important to bring commercial for-profit payers to the table.

Work group members also expressed an interest in making criteria #4 (Implement specific program interventions initially in areas that are "hot spots"…) more specific. One work group member wanted to explicitly include the uninsured and undocumented residents of a community. However, federal dollars cannot be used for services for undocumented individuals. There are high rates of health disparities in this group and they often seek care in expensive settings such as the emergency room. Furthermore, Akron's model included the uninsured. It will be important to think about what drives people to focus on hot spots. Decreasing disparities in a given community will be an important driver.

Work group members discussed balancing between primary/upstream work and secondary or tertiary interventions. While the upstream work has an ROI that is many years out, the more downstream work will show savings within three years. Work group members wondered if there was a way to tie these short-term savings into investments upstream or if the ACC could expand its geography after the initial three-year period.

Barbara Masters then distributed a table which shows "Population Health Improvement at All Levels of Health Need" from Maryland. This table divides the population into four categories organized into a pyramid. "Super utilizers" are at the top of the pyramid, followed by "chronically ill & at risk of becoming a super utilizer." Third is "chronically ill but under control" and at the bottom of the pyramid is the category for healthy people. Feedback from the work group members suggested that there should be a category between "chronically but under control" and "healthy." This category would contain people who are pre-diabetic or obese. Work group members also commented that if this pyramid represented costs, it would be flipped upside down.

Work group members were asked to think about synergistic strategies which affect multiple bands of the pyramid (e.g., case management, community level interventions such as a walking club). If, ultimately, an ACC's goal is to move upstream towards primary prevention then proposals should show a strategy to accomplish this. This may require partnerships with counties, for example. Crosscutting interventions may span across generational lines. Also, if an ACC is to work in communities with a high percentage of vulnerable populations then it should have strategies to address housing metrics, food instability, screening metrics, social/environmental factors that influence disease progression in community. This may be a stretch but if a proposal addressed this it should be looked at favorably. However, it would be challenging to gather the data on all of these community level factors.

Work group members then discussed criteria #2 "reach 75 percent of individuals in the geographic area with that condition." This criteria would apply to everyone in the defined area, not just an individual plan's population. Work group members warned against focusing too much on the reach and not enough on the depth of the intervention. It was noted that explicit strategies

to achieve depth of services for high needs areas would be helpful. Work group members also questioned whether the population would include members who are at risk of developing a chronic condition (e.g., prediabetic).

B. Backbone/Integrator Functions

The Akron ACC had an entity that was explicitly designated to facilitate the functioning of the ACC, including managing the data arrangements. In previous discussions, the work group agreed that this was an important and necessary feature for ACCs in California.

In defining the backbone/integrator function, further several key questions arose: is this a backbone or a community coalition, who is the backbone organization accountable to and for what, and is this group a subgroup of a larger coalition? Work group members also emphasized that the ACC would need an independent evaluator to monitor how the backbone is functioning.

The key functions of a backbone/integrator in a community would be to establish a governance structure and manage the fiscal piece for the ACC, including potentially facilitating the wellness trust. Functions may include setting up a 501c3 to manage the funds from the wellness trust. There may be a need to establish quality standards across all entities participating.

Additionally, the backbone entity would need to be able to take responsibility for the leadership of the ACC, including working with competing health systems and facilitating a shared savings model. Someone would need to understand both the vision of the ACC and the commercial interests, as well as manage constant turnover and bring new people into the ACC. For this reason, some work group members believe that the backbone/integrator would have to be an independent entity rather than a coalition. CDPH has some experience of this within HiAP – while the backbone team is facilitated through CDPH, they are accountable to a cabinet level organization (the strategic growth council). This governance allows for accountability.

C. Wellness Trust

Key questions surrounding the wellness trust include: where would the money come from, how would distribution of the money be structured, what will the money go towards, what practices and capacities are necessary to manage a wellness trust, and how to develop shared fiscal responsibility going forward. Work group members wondered what sort of entity would have the credibility to manage the relationships between the multiple payers and the pooled resources.

Work group members questioned whether a "wellness trust" was the appropriate name for this type of entity. The entity will be a central funding authority. Although this model is different from Massachusetts' state model, this is still a vehicle for pooling shared savings, as the name applies. One work group member cautioned that hospitals will not be interested in participating if they are required to pool all of their community benefit dollars.

Work group members also wondered whether a wellness trust would have to be established at the outset. There was agreement that having a vehicle for pooling resources and receiving seed funding at the outset would be beneficial. Also, there needs to be a neutral home for the monies and a formal strategy for distributing them. This may be as simple as memorandums of understanding between parties which set up a collective decision making process.

The key functionality of a wellness trust would include:

- A vehicle for collecting funding at the outset
- Connected to the governance structure of the ACC
- Collective decision making about use and distribution of resources
- A vehicle to capture savings and reallocate them upstream

The wellness trust will require buy-in and participation of health plans. One possibility for "selling" this idea to health plans is to take the savings from the interventions from commercial plan members and reinvest them back into Medi-Cal beneficiaries. Partnership Health Plan already reinvests money from Medi-Cal. A key difference is that the plans would be putting this money into a community pot and collectively making decisions about those dollars. If hospitals lose a huge source of revenue, the group does not want to penalize them for investing in primary prevention. One work group member suggested that the wellness trust be cost-neutral for plans – the wellness trust invests in primary or secondary prevention on their behalf. The trust could also support interventions which are efficacious and efficient. This could be positioned as being a win-win for the plans.

One work group member cautioned that the goal is to reduce health care costs overall – therefore, not everyone will be winners. Furthermore, although there will need to be a piece that goes back to the healthcare sector as an incentive, some of the monies will be reinvested outside of the healthcare sector.

Work group members will need to decide what the relationship is between the backbone entity and the wellness trust. If the backbone entity is viewed as a facilitator, they are responsible to the larger ACC collaborative. The group liked the idea that the distribution of the wellness trust funds should be partially driven by community organizations that are not directly linked to the health sector (e.g., schools). This type of trust would require a community decision making strategy to be in place. The wellness trust is not only pooled money – it represents an investment strategy. This requires a different kind of fiscal management and accountability. The organization responsible for the distribution of funds will need to be able to track the ROI seen by that investment. Unless there is a "value add," investors should not become part of the ACC.

In previous work group meetings, members had discussed asking for either a financial commitment or an in-kind commitment from entities participating in the ACC upfront. Over time, a formal accountability plan would develop. Work group members stressed that the wellness trust or the backbone entity will be responsible for tracking the clinical outcomes and fiscal savings. Establishing a clear relationship and delineating responsibilities at the outset will be a key strategy.

After much discussion, work group members agreed that it would be important to lay out the key functions of a wellness trust and allow for local uniqueness within proposals, as well as outline several examples of a successful wellness trust, and the relationship between a wellness trust and a backbone entity. One possibility that was discussed was the wellness trust being a local foundation linked to the ACC by the backbone organization.

III. Potential Research Needs

Previously work group members discussed the following research needs:

1. Literature review and analysis regarding chronic conditions, interventions and potential ROIs
2. Wellness Trust: governance options and implications; minimal or optimal size; legal issues related to pooling resources from government programs, hospital community benefits, health care financing programs
3. Models and mechanisms for data sharing across systems, including health information exchange; linking population health data with clinical data; data needs for hot spotting
4. What examples exist for determining shared savings that are most applicable to an ACC and how might they be expanded to capture impacts in the non-healthcare sector?
5. Learnings from Community Transformation Grant (CTG) experience with regard to partnerships between community, clinics, and local health departments: what type of processes or structures have been most successful and what type of data collection is occurring
6. Population size and geographic reach of different population health interventions
7. Training needs for providers to help them make practice changes
    - Note: UC Berkeley is currently analyzing national survey data from 170 ACOs around the country.
8. Tools to assist patients in increasing their health literacy.

Work group members were to identify which research needs were a high priority:

- Conducting a literature review regarding which chronic conditions have the most potential to demonstrate an ROI is considered high priority (#1). A key question would be how large of a population is needed to establish a proof of concept.
- In addition to this, #2-4 will be helpful. Work group members acknowledged that #3 will be challenging. #4 may be challenging as well since many ACOs do not know how they are going to share the savings that they have demonstrated..

Work group members were also asked if there were any other research needs:

- Identify a nexus of primary and secondary interventions, and potential ROIs associated with these interventions. This can be used to inform communities applying and the selection process.
- Identify areas across the State that have promise.
- Identify how large of a population is needed for success.
- To the extent that there have been successful models, identify how much implementation costs and describe data sharing arrangements.
- Identify 12 month benchmarks.
- Figure out which preconditions lead to effective models of shared savings.
- Figure out the potential for shared savings in other organizations (criminal justice, schools, etc.).

IV. Potential Names

Work group members brainstormed potential names for the ACC. Words which convey this idea included: Accountability, Alliance, Community, Consortium, Health, Healthy Systems, and Integrative. From these words, one option that arose was: Accountable Community Health Alliances (AHCA).

V. Next Steps

Barb will reach out to folks with a doodle poll to schedule future meetings. Barb will reach out to Pat to see if this work group can coordinate with the work group on Health Homes and the work group on Community Health Workers.